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The Future of Abortion

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by

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I. Introduction

Is there any surprise at the emotional and political reaction to President Bill Clinton's veto of the partial birth abortion bill? No? Yet, perhaps what is surprising is the emotional outcry against this procedure as compared to the political and social apathy during over 20 years of abortion (within the United States). Why such a reaction from pro-life and Church leaders now; when the same leaders never unleashed the same fury and media coverage during the past 23 years of abortions? Perhaps the answer will yield clues to the future of abortion in the U.S.

Meanwhile, the availability of abortion clinics and doctors is slowly dwindling. Organized protests at clinics, doctor's homes, and malpractice suits against abortion doctors have contributed to the decline of abortion service availability. With the decline in available abortion facilities and physicians, how will abortion continue as a method of eugenics and population control, as well as an erroneously described "reproductive right"? Perhaps the answer lies in the future direction of abortion in the U.S.

II. Technology Development

As technological advances in the fields of endocrinology, biotechnology, immunology, and pharmacology progress, the creation of new abortifacient technologies will continue. Furthermore, these technologies will target the destruction of life at an ever-earlier stage of development. The movement of technologies to destroy life will continue to focus at the embryonic (up to 2 months of development) stage. This statement is exemplified by the recent Food and Drug Administration (FDA) approval of the double-dose birth control pills and FDA market approval of RU-486 (Mifepristone). The purpose of the double-dose birth control pill is to block uterine implantation of an early stage embryo, whereas the progesterone blocking action of RU-486 acts to terminate embryonic life up to the first 49 days of development.

Beyond these recently approved drugs, the development of other embryonic stage abortifacients (such as more advanced progesterone blockers and ETF) is continuing. Furthermore, the development of an abortifacient vaccine is nearly complete.[1,2] This technology does not block ovulation or conception, but rather blocks embryo implantation and leads to embryonic death, which appears as a menstrual period. This technology is targeted for world distribution. The vaccines will mislead many into believing that they are using a safe, effective form of birth control, when in reality, the vaccine will engineer a monthly abortion. The vaccines' effects will last for 18 months.

The early embryo destructive effect on many of these products brings us to the next clue to the future of abortion.

III. Moving Away From Fetal Death

Advances in technology will reduce the fetal body count while vastly increasing the embryonic fatalities. As a consequence, this may increase societal acceptance of abortion. How?

The abortifacient technologies will destroy life at an earlier stage. Market studies for RU-486[3] alone claim that the product could capture up to 60% of the clinical surgical abortions in the U.S. Other technologies could surpass that figure.

Furthermore, one method that pro-life uses to convey the humanity

or "humanness" of the fetus is to display graphic photos of fetuses with well-formed fingers, eyes, hands, toes, a heart beating, etc. Advanced abortifacient technologies act to destroy the life in the embryonic (e.g. trophoblastic) stage well *before* toes, eyes, hands, etc., are formed. Also, it will be harder to emotionally associate with a "hollow ball of cells" (as in the case of the trophoblastic embryo) than with a human-shaped fetus. In essence, the myth that abortion just removes a "blob of cells or tissue" will be reinforced.

Even now, the beginning of life is being redefined at the uterine implantation stage (aka nidation), rather than conception. This redefinition allows justification for such medical activities as human embryo experimentation and the recently publicized incident in Britain of the disposal of thousands of human embryos. This redefinition has been supported by the National Institute of Health (NIH) and the American Fertility Society (AFS).[4,5]

This new redefining of the pre-embryo as not totally human life affords not merely research on human embryos, but expanded use of abortifacients that destroy early life by killing the pre-embryo or blocking uterine implantation (Remember: blocking uterine implantation leads to rapid death of the embryo). At present, some forms of birth control (e.g. Intrauterine Devices [IUD] and some versions of the birth control pills), already block embryonic implantation into the uterus.

It must be further noted that as more data arises on the complications due to surgically induced abortions, marketing strategies for abortifacient products will capitalize on this data as a motivational factor toward more embryo stage-directed abortifacients. Simply put, pharmaceutical corporations will use available data on abortion complications (e.g. abortion and infertility link; abortion and breast cancer link, etc.) to convince the consumer to use birth control that in reality is abortifacient in nature. As the population of consumers accepting this technology increases, total surgical abortions will rapidly decrease, while the total number of abortions will rise exponentially. In reality, the population will increasingly be deceived into accepting abortifacients as a version of effective birth control.

The shift from surgical abortions to pharmaceutical abortifacients brings us to the next aspect of the future of abortion.

IV. Pharmaceutical Abortifacients

The market shift to pharmaceutical abortifacients has some advantages. First, this technology reduces the role of clinics and doctors. Doctors need not use a clinic to prescribe or dispense pharmaceutical abortifacients. Rather, doctors may dispense these drugs (or vaccines) in their office and such actions will be protected by doctor-patient confidentiality. Also, as previously noted, increasing dissemination of pharmaceutical abortifacients will lead to a decrease in surgical abortions. As surgical abortions decrease, this will reduce abortion clinic revenues. Eventually, the declining revenues may force many clinics to close. Although some clinics may continue to exist by virtue of distributing abortifacient drugs, the most cost effective measure for physicians (and health care providers like HMOs and PPOs) will be abortifacient distribution at the physician's office.

This shift in abortion (from surgical means to pharmaceuticals) will further favor the physician in another way.

One of the strong deterrents for physicians working in the abortions industry is malpractice suits. In recent years, a combined force of pro-life advocates and legal professionals have unleashed a torrent of malpractice suits due to botched abortions. As a result, physician participation in the abortion industry has declined as malpractice suits and malpractice financial settlements have climbed. As abortifacient technology favors pharmaceuticals, the resultant legal/financial responsibility shifts away from the sole physician towards the larger (and more legally formidable) pharmaceutical corporations. The costs of malpractice insurance would be comparably lower (by dispensing abortifacients) even though the physician's participation in abortion would continue. Malpractice suits would be replaced by drug manufacturer law suits which are more lengthy, costly, and more difficult to win. Furthermore, recent FDA bias toward RU-486 may require future lawsuits against this federal agency. Law suits at this level are even more lengthy and difficult (if not impossible) to win.

The distribution of abortifacients by doctors may make abortion more palatable to physicians. One case in point, a 1995 Kaiser Family Foundation survey[6] has found that doctors who would not perform surgical abortions would prescribe the abortifacient drug,

RU-486. Furthermore, the same survey demonstrated that a majority of the doctors who do not perform abortions have prescribed the "morning after pill" for emergency contraception. As more abortifacient products enter the marketplace, physicians (even with their knowledge base of endocrinology, pharmacology, and gynecology as well as the understanding of the consequences of the use of abortifacient drugs and vaccines) will increasingly turn to prescribe these products to terminate early stage pregnancies.

Finally, as abortifacient pharmaceuticals rise to the predominant form of abortion, another important marketing strategy will eventually influence the future of abortion.

Recently, Americans have enjoyed the non-prescription availability of commonly used pharmaceutical products like Nicorette tm gum, Tagamet™, Zantac™, Rogaine™, and Naproxin (aka Alleve™). The process to move a prescription drug to an over the counter drug status (commonly referred to as Rx-to-OTC conversions) has been accelerating during this decade. Usually, the motivational factor for this conversion is the end of the pharmaceutical firm's exclusive marketing of this product as its patent expires.

At present, the only drugs that the FDA will absolutely not allow Rx-to-OTC conversions are narcotics. It is conceivable that eventually some abortifacients pharmaceuticals (as their patent comes up to the expiration date) will become available over the counter. Women could one day in the near future obtain abortifacients in the discount drug stores as easily as purchasing aspirin, antacids, panty hose, or nail polish!

V. Counterstrategies

With the future of abortion being directed towards pharmaceutically-based abortifacients which target destroying life early in development, pro-life advocates will face a series of unique challenges. It must be noted that along with abortifacient technology developments, society will increasingly challenge the definition of when life begins. For example, some abortifacient vaccine advocates, including HCG vaccine (i.e. abortifacient vaccine) researcher Dr. G. F. Talwar[7], state that life begins not at conception, but when the embryo

implants itself into the uterine lining (i.e., nidation).

As these redefinitions of the genesis of life continue, disguised under the cloak of scientific authority, pro-life advocates must become scientifically and technologically astute with the technologies and issues at hand. Sadly, one of the critical weaknesses that many major pro-life groups have is a paucity of scientists and technologically trained staffers proficient in the fields of medicine, pharmacology, embryology, molecular biology, immunology, biotechnology, and biochemistry. Many groups may feebly attempt to occasionally seek out a retired medical advisor, but the true weakness of pro-life is their absence of a permanent scientific staff. As some groups continue to chant a pro-life mantra, their absence of a staff technically aware of the new abortion technologies will only demonstrate how these groups have been poor stewards of the funds they have been entrusted with by their contributors. In short, as the world becomes even more complex, pro-life forces must become staffed with knowledgeable individuals who can decipher, comprehend, and articulate to the general public which technologies promote a culture of life and/or a culture of death. To do less, is both financially and morally wrong!

It must be noted that the Alan Guttmacher Institute is the research arm of Planned Parenthood. This institute has a PERMANENT staff of scientists and researchers who actively conduct research and publish their work (much of it advocating abortion and contraceptive technologies) in peer-reviewed journals, gaining the respect and attention of the medical and scientific community as well as the American public at large.

Another weakness within pro-life is the classic conflict between being pro-life, but condoning contraception. This is interesting as it was contraception that legally heralded abortion (i.e. *Roe v Wade,* 1973) via the Supreme Court decision of *Griswold V. Connecticut,* (1965). But, beyond legal considerations, many pro-life advocates still remain silent or in a state of neo-denial over the relationship between contraception and abortion. As contraception helped to crystallize the concept of "Babies/children can be a burden" in the American psyche, abortion became the accepted means to deal with the "problem". In short, abortion followed as a "solution" to the "problem" of pregnancy.

Despite medical and pharmaceutical data going back to the 1960s demonstrating that certain forms of birth control (e.g. birth control pills) did in fact induce a very early stage abortion (example: via blocking the implantation of the embryo into the uterine lining), some elements of the pro-life community have remained silent, choosing rather to focus on fetal surgical abortions. With this continued schizophrenic mentality, these pro-life elements will become effectively shut out (and silenced) in the abortion debate, as the future of abortion progresses towards pharmaceutical early stage techniques. In essence, as the world is being told that the new abortifacients are just "birth control"; and as the beginning of life is reclassified at nidation, not conception; then the pro-contraception pro-life forces will, by default, surrender and become silent in the debate. Meanwhile, more lives will be lost amidst the silence over these technologies.

The counterstrategy to this scenario may require vigorous education on two fronts. First, reeducation and active discussion to break the myth that life begins some time AFTER conception. Second, discussion on the real connection between contraception and abortion.

Finally, a sad but real third possible strategy includes public exposure of the "Fifth Column" pro-life organizations or leaders that quietly accept future abortifacient "contraception". This strategy is admittedly painful and publicly unpleasant, but in the future, it may be required. As some physicians and therapists have pointed out, "The first step to healing the patient is admitting or identifying the ailment in question."

Conclusions

The future of abortion is a future which will involve technologies that destroy life at a much earlier stage of development. As such, it will increase public acceptance of abortion; reduce the overall costs to pro-abortion facilities; reduce reproductive responsibility; and mute much of the societal emotional response to those destroyed in the womb. Pro-life will face a plethora of new technologies. These technologies will increase the abortion casualty numbers, increase abortion access, and reduce the educational opportunities to the general public.

The response to the future of abortion is two-fold. The challenge to pro-life will require the acquisition of scientific and technological staffers who can comprehend and educate the public on these technologies and their consequences.

Furthermore, a reexamination of the connection between contraception and abortion is required. The strong wall separating these two concepts must be pulled down and the public must be thoroughly educated on the close ties between abortion and contraception - both psychologically and technologically. Those pro-life forces that fail to do this may be faced with a future of obsolescence.

Finally, should pro-life forces fail to warn society about the future of abortion and its implications, American society itself may eventually be faced with obsolescence.

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